

Instructions for Completing Permanent Data Forms

For new Participants, if you are adding a Dependent, or if you are changing your life beneficiary:

- If you are married, please attach a copy of your marriage certificate.
- If you have dependent children or stepchildren, please attach a copy of each child's birth certificate. (NOTE: If you are retired, your children, adopted children and stepchildren are not covered unless they were covered while you were an active participant.)
- If you are claiming stepchildren as dependents, note that such children must reside with you and be dependent on you for support and maintenance. Please attach a copy of your most recent IRS Tax Form that indicates the child's residence with you and your support of that child. A copy of the portion of your spouse's divorce decree that pertains to responsibility for the child's medical care (if applicable) will also be required.
- If you are divorced and are claiming dependent children, please provide a copy of the portion of your divorce decree that pertains to responsibility for the child's medical care. If the parent with custody is not the member and is remarried, the Plan will require a notarized statement that such parent and new spouse either has or does not have available coverage for the child.
- If you are changing your life beneficiary, please complete page 2 and page 3 in it's entirety.

Dependent Parents

Parents may be claimed as dependents only if (1) you do not presently have a spouse and you do not have children under age 19 (or 23, if full-time students), and (2) you have contributed at least one-half of the support of the parent being claimed as a dependent, and that you can verify this support by submitting a copy of your IRS Tax Form for the preceding calendar year. You will be requested to provide proof of the dependency of your parent(s) annually.

Students

Children are covered under the Plan until their 19th birthday. If your child is age 19 but less than age 23 and a full-time student, the Plan will continue to cover your child as long as he/she remains a full-time student. Student status forms are available from the Plan Office or on the Plan website (www.mebaplans.org). Proof of full-time student status will be required each year.

Change in Marital Status

- If you are married and become divorced or legally separated, please submit a copy of your divorce decree or legal separation agreement with your new Permanent Data Form.
- If you are single and get married, please submit a copy of your marriage certificate with your new Permanent Data Form.

Note About Address Changes

If you are advising the Plan of a change of address only and have no other changes to make, it is not necessary for you to complete a new Permanent Data Form! Simply write to the Plan Office, making sure to include the Participant's name and social security number. The Participant must sign this letter in order to allow the Plan Office to change the address records.

If you use a PO Box address, the Plan Office will require a physical address also.

PERMANENT DATA FORM

COMPLETE BOTH PAGES OF THIS FORM, SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name	Last Name			First Name			Initial		
Social Security Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>
Date of Birth	/ /			Sex (Check One)	<input type="checkbox"/> Male				
	Month	Day	Year		<input type="checkbox"/> Female				
Home Telephone Number	(Area Code: <input type="text"/> <input type="text"/> <input type="text"/>)			-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellular Phone Number	(Area Code: <input type="text"/> <input type="text"/> <input type="text"/>)			-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail address (If applicable)	<input type="text"/>								
Affiliation (Check One)	<input type="checkbox"/> District No. 1-PCD, MEBA <input type="checkbox"/> Plan Employee <input type="checkbox"/> Union Employee <input type="checkbox"/> Other:								
Active/Pensioner (Check One)	<input type="checkbox"/> Active <input type="checkbox"/> Pensioner			If Actively Employed, Name of Present Employer:					
Marital Status (Check One)	<input type="checkbox"/> Single			<input type="checkbox"/> Married			<input type="checkbox"/> Widowed		
	<input type="checkbox"/> Divorced			<input type="checkbox"/> Legally Separated					
Date Married, Divorced, Legally Separated or Widowed:	/ /								
Permanent Address (Home of Record):	Number & Street								
	City, State, Zip								
Mailing Address (if different than Permanent Address above):	Number & Street								
	City, State, Zip								

**DEPENDENTS TO BE ADDED TO YOUR MEDICAL COVERAGE
(LIST FULL NAMES)**

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDENT SSN	RELATIONSHIP TO MEMBER	CHECK IF FT STUDENT
				<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>		
				<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>		
				<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>		
				<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>		
				<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>		
				<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>		
				<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>		

BENEFICIARY DESIGNATION:

I designate the following person(s) as my beneficiary (ies) to receive benefits which may be payable from the MEBA Medical and Benefits Plan upon my death. I revoke all previous beneficiary designations and make the designation of beneficiary(ies) shown below with respect to benefits provided now or at any time in the future under the above Plan, still reserving to myself the privilege of making other and future changes subject to the Plan provisions. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise provided herein. If no beneficiary survives me, settlement will be made in accordance with the provisions of the Plan. **NOTE: Co-beneficiaries receive proceeds in equal shares, unless otherwise indicated. Contingent Beneficiary is the person who will receive the proceeds if the primary beneficiary should predecease the person whose life is insured.**

Name: Check One: <input type="checkbox"/> Beneficiary <i>or</i> <input type="checkbox"/> Co -Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Percent (%) of Benefit:	_____ %
Date of Birth	/ / Month Day Year		Sex (Check One)	<input type="checkbox"/> Male <input type="checkbox"/> Female

CO-BENEFICIARY (IES) OR CONTINGENT BENEFICIARY (IES)

Name: Check One: <input type="checkbox"/> Co-Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Percent (%) of Benefit:	_____ %
Date of Birth	/ / Month Day Year		Sex (Check One)	<input type="checkbox"/> Male <input type="checkbox"/> Female

Name: Check One: <input type="checkbox"/> Co-Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Percent (%) of Benefit:	_____ %
Date of Birth	/ / Month Day Year		Sex (Check One)	<input type="checkbox"/> Male <input type="checkbox"/> Female

(Attach a separate sheet to your Permanent Data Form if you have more than two Co-Beneficiaries)

Signature of Employee	Date
-----------------------	------

**FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.**